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Issue Date: 15 November 2006

IN THE MATTER OF:

L. W.,
Claimant

v. Case No.: 1984-BLA-9098

PEABODY COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

SEVENTH DECISION AND ORDER ON REMAND AWARDING BENEFITS[1]

This case involves the claim of L. W., who filed his original claim for benefits on April 27, 1978. The case has been appealed to the Benefits Review Board (Board) seven times, and the full procedural history can be found at *Whitman v. Peabody Coal Co.,* BRB 01-0130 BLA, December 19, 2001 (fn. 2). As pertinent herein, the Board has remanded this claim for further consideration of the issues as set out below, in a Decision and Order issued on March 28, 2006. The file was received in this office on July 6, 2006. On July 12, 2006, 2004, I issued an Order Setting Briefing Schedule, providing the parties 30 days to submit briefs addressing the issues raised by the Board. The Claimant filed his brief on October 11, 2006; the Employer filed its brief on October 4, 2006; the Director did not file a brief.

The Board, in its most recent *Decision and Order* dated March 28, 2006, upheld my finding of invocation under 20 C.F.R. § 727.203(a)(2) through weighing the pulmonary function study evidence. However, the Board directed that the medical evidence be reweighed to determine whether the interim presumption may be rebutted under § 727.203(b)(3) or § 727.203(b)(4).

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[1] Title 20 C.F.R. § 725.477(b) provides that "A decision and order shall contain . . . the names of the parties . . . ." In spite of this regulatory requirement, and the fact that by statute and regulation, black lung and longshore hearings are open to the public, the Department of Labor has decided that in order to limit a claimant's "exposure" on the Internet, it will avoid referring directly to the claimant's name in decisions and other orders that are required to be posted on the DOL web site on or after August 1, 2006. Thus, as directed by Chief Administrative Law Judge John M. Vittone, I am required to refer to the Claimant and members of his family by initials only.

I
Pulmonary function studies

In order to weigh the medical opinion evidence in accordance with the Board's directives, I note that the following pulmonary function study reports have been admitted as evidence in this claim:

Exhibit Number Date of study Physician	Age/Height Tracings	Pre-bronchodilator	Post-bronchodilator	Qualify?
Dx. 8 11-20-78 Simpao	55 years old 71" yes	FEV1 = 2.83 FVC = 3.34 MVV = 126		**No**
Dx. 9 04-21-81 Calhoun	58 years old 71" yes	FEV1 = 2.05 FVC = 2.35 MVV = 86		**Yes**. This study was validated by Dr. S. Kraman by report dated April 19, 1987. *Dx.* 9.
Dx. 24 09-24-81 Anderson	58 years old 70" yes	FEV1 = 3.35 FVC = 4.07 MVV = 138		**No**.
Dx. 24 10-15-81 Gallo	58 years old 71" yes	FEV1= 3.35 MVV = 138		**No**
Dx. 25 12-15-82 Getty	59 years old 71" yes	FEV1=2.73 FVC = 3.25 MVV = 97	FEV1 = 3.14 FVC = 3.76 MVV = 106	**No**
Cx. 3 06-10-86 Calhoun	63 years old 71" yes	FEV1 = 2.55 FVC = 3.10 MVV = 70		**Yes**. By report dated August 15, 1986, Dr. Anderson concluded that the test was invalid because of unacceptable variances among the trials. *Ex.* 4.
Cx. 5 09-09-86 Regional Medical Center	63 years old 71" yes	FEV1 = 2.10 FVC = 2.48 MVV = 40		**Yes**. Claimant underwent this study at Employer's request because the qualifying June 10, 1986 study was invalid. Because this study also yielded qualifying results, it was submitted by Claimant. Dr. O'Bryan reviewed the results of the study and determined that they were not valid because the FVC results were "not reproducible." *ALJx.* 3.
ALJx. 3 02-08-00 O'Bryan	76 years old 71" (see comments) yes	FEV1 = 2.05 FVC = 2.47 MVV = 51	FEV1 = 2.41 FVC = 2.88 MVV = 57	**Yes**. The Board held that the appropriate height for the miner is 71 inches and that I properly used the table values for 71" in determining whether the February 8, 2000 pulmonary function study was qualifying.
ALJx. 5 08-30-02 Simpao	79 years old 69" yes	FEV1 = 2.04 FVC = 2.71 MVV = 46	FEV1 = 2.30 FVC = 2.89 MVV = 80	**Yes**. Dr. Simpao stated that the test revealed a "moderate degree of both restrictive

				and obstructive airway disease." In his November 10, 2002 report, Dr. Fino determined that the study was invalid because of "premature termination to exhalation and a lack of reproducibility in the expiratory tracings." *ALJx.* 8.
ALJx. 7 10-02-02 Powell	79 years old 69"	FEV1 = 2.22 FVC = 2.79 MVV = not conducted		**The FEV1 qualifies**. In my July 10, 2003 *Decision*, I stated that it was "unclear" whether the test qualified because no MVV values were provided as required by the Part 727 regulatory tables.

I previously found that the February 8, 2000 study conducted by Dr. O'Bryan was valid and qualifying and, based on this study in conjunction with other recent studies of record, the interim presumption at 20 C.F.R. § 727.203(a)(2) was invoked. As the Board has upheld this finding, it will not be revisited here.

II
Summary of the medical opinions

Dr. Valentino Simpao

Dr. Simpao examined and tested Mr. W. on November 20, 1978 and issued a report on December 14, 1978. *Dx.* 12. Dr. Simpao reported that Mr. W. complained of significant productive cough of at least three months per year of 22 years in duration. He noted 25 years of coal mine employment, and that Claimant was still employed in the mines, but was experiencing increased shortness of breath. Dr. Simpao also noted that most of Claimant's work in the mines was at the tipple "where all the heavy, dusty atmosphere is involved." He explained Mr. W.'s symptoms during the examination:

> His cough is mostly noted in the early morning hours or late evening. His shortness of breath has been progressively worse, especially in the last three or four years. He has noticed that he is getting worse because climbing up steep hills or stairs is making him very short of breath. When he talks in a faster manner, he claims he has to stop once in a while in order to have a breather to continue his conversation.
>
> He has a problem sleeping at night because his chest gets congested so that he has to cough up some material in order to have a good night's rest.

On examination of Mr. W.'s lungs, Dr. Simpao noted increased resonance on percussion. On auscultation, "there (was) some rhonchi and crepitation," but no "wet rales." Dr. Simpao also noted occasional wheezing. He diagnosed the presence of chronic pulmonary fibrosis and

chronic bronchitis. Moreover, Dr. Simpao stated that Mr. W.'s pulmonary condition "could be" caused by his work as a coal miner and that his "pulmonary disability appears to be total."

Dr. Simpao was affiliated with the Coal Miner's Respiratory Clinic at the Muhlenberg Community Hospital.

Dr. Simpao testified by deposition on May 27, 1982. *Dx.* 23. He stated that he was a 1957 graduate of the University of St. Thomas Medical School in the Philippines. *Dx.* 23 at 3. Dr. Simpao served as a staff physician in New York as well as in Paris, Kentucky. *Dx.* 23 at 4. He recalled that in Paris, Kentucky, he served as "a medical director of a state tuberculosis hospital from 1966 to 1970." *Dx.* 23 at 4. At the time of the deposition, he worked as a general practitioner. *Dx.* 23 at 4.

Dr. Simpao stated that he treated coal miners for respiratory conditions in his general practice and he had been appointed by the Department of Labor to conduct examinations of miners to assess whether they suffered from coal workers' pneumoconiosis. *Dx.* 23 at 4-5. His examinations of coal miners were conducted at the Coal Miners' Respiratory Clinic at the Muhlenberg Community Hospital where he served as the Medical Director. *Dx.* 23 at 4-5.

With regard to his examination of Mr. W., Dr. Simpao stated, "Basing on the medical history and the physical findings, along with the chest x-ray and other objective findings, I infer that this patient is suffering from coal workers' pneumoconiosis." *Dx.* 23 at 10. He stated that the Category 1 findings on the chest x-ray were caused by Mr. W.'s 25 year history of coal dust exposure. *Dx.* 23 at 12. When asked to address the cause of Mr. W.'s chronic bronchitis, Dr. Simpao replied, "The environmental effect – or rather, some inhalation of dust might cause this kind of irritation in the bronchial tree." *Dx.* 23 at 12. Dr. Simpao concluded that pneumoconiosis and chronic bronchitis rendered Mr. W. totally disabled. *Dx.* 23 at 13.

When asked to set forth the physical findings in support of chronic lung disease, Dr. Simpao stated:

> On examination of the patient, his general appearance, he had the plethoric appearance; and also in his chest we noted he had rhonchi and crepitation and wheezing . . ..

Dx. 23 at 13. Dr. Simpao also pointed to shortness of breath and "cyanotic changes in (the miner's) lips . . . and fingernails." *Dx.* 23 at 13-14. Although ventilatory testing underlying his report yielded non-qualifying values, Dr. Simpao reasoned that Mr. W. was disabled, and stated that "in (his) opinion of (Claimant), along with the clinical findings or subjective findings, and physical findings of the patient, I infer there is an impairment in this particular patient—some pulmonary impairment." *Dx.* 23 at 16.

Dr. Simpao stated that there was no indication of arteriosclerotic heart disease at the time of his examination of Mr. W. *Dx.* 23 at 16. Dr. Simpao noted:

> His heart finding at the time, it's regular rhythm and no murmur or thrill that we noted in his chest. Just by physical findings, I didn't see it; but along with his old age, he could have some sort.

Dx. 23 at 16-17. Dr. Simpao was not aware that Mr. W. underwent coronary bypass surgery shortly after his February 1980 retirement. *Dx.* 23 at 17.

Dr. Thomas Calhoun

Dr. Calhoun examined and tested Mr. W., and issued a report on April 21, 1981. *Dx.* 10. Dr. Calhoun noted that he had treated Mr. W. in the 1950s and 1960s for nervousness "when (he) practiced at Madisonville, Kentucky." Mr. W. reported that he was disabled from working in the mines in February 1980, and that he had "heart trouble." Dr. Calhoun noted that the purpose of Mr. W.'s visit was to determine whether "he would be considered disabled for coal mining or similar work because of pneumoconiosis." He stated that Mr. W. never smoked, but he "has a lot of emphysema" based on his chest x-ray study and this "must have developed as a result of his mining, welding, electrical work, and his exposure to other materials other than cigarette smoking." He reported 27 years of coal mine employment. During the examination, Mr. W. did not complain of wheezing, and Dr. Calhoun noted that he had "little or no coughing and he produces very little sputum though he used to cough up sputum and did wheeze some when he worked as a miner." The chest x-ray was interpreted as revealing Category 1 pneumoconiosis. According to Dr. Calhoun, pulmonary function testing revealed "crippling" results.

Dr. Calhoun observed signs of early clubbing of the fingernails. Examination of the lungs revealed that "breath sounds were reduced in their intensity and their duration throughout both phases of respiration." Cardiac examination yielded normal findings. Dr. Calhoun did note that Mr. W. had undergone triple by-pass surgery in March 1980. He diagnosed the presence of coal workers' pneumoconiosis based on Mr. W.'s chest x-ray results, and he concluded that Mr. W. suffered from arteriosclerotic heart disease by history. Dr. Calhoun concluded that Mr. W. was "a terrible pulmonary cripple" and that he could not "find anything in (his) history that would cause pulmonary disease except exposure to coal dust and rock dust." Physical findings of "far-advanced chronic lung disease" included notations that Mr. W. had (1) a large, voluminous symmetrical chest, (2) marked hyper-resonance to percussion, (3) "low, distant, hard to hear breath sounds," (4) a "poor pulmonary excursion of one inch," (5) widening of the ribs, and (6) the fact that the "anterior costal margins flared forward." Dr. Calhoun concluded that Mr. W. was totally disabled due to coal workers' pneumoconiosis and chronic obstructive pulmonary disease arising from exposure to coal dust, as well as from heart disease. In an addendum to his report dated April 22, 1981, Dr. Calhoun reported that Mr. W.'s OT and histological skin tests produced negative results.

Dr. Calhoun's letterhead indicated that he was a practitioner of general medicine.

Dr. Thomas A. Gallo

Dr. Gallo examined and tested Mr. W., and issued a report on October 15, 1981. *Dx.* 24. He reported 28 years of surface mining at a strip mine, "mostly in electrical maintenance and

electrical repair." Dr. Gallo noted that Mr. W. quit working in February 1980 because "he had noticed increasing dyspnea such as walking up about 20 steps accompanied by anterior chest discomfort." Mr. W. reported that he learned that he suffered from coronary artery disease, and he underwent coronary by-pass surgery in March of 1980. Dr. Gallo noted that Mr. W. walked half a mile before he noticed dyspnea and, "there is some cough but it is normally nonproductive." Mr. W. reported that he never smoked and did not have a history of tuberculosis. Examination of the chest revealed that it was clear with "no rales or wheezes." Cardiac examination revealed distant heart sounds. An x-ray was interpreted as negative for the presence of pneumoconiosis. Blood gas testing produced evidence of "borderline hypoxemia," but the values were non-qualifying. An EKG revealed "some nonspecific T-wave changes, otherwise no diagnostic changes." Dr. Gallo concluded that Mr. W. suffered from "status post-coronary by-pass surgery for coronary artery disease with angina pectoris."

Dr. Gallo testified by deposition on February 18, 1982. *Dx.* 24. He graduated from the University of Cincinnati School of Medicine with a medical degree in 1967. He was board-certified in internal medicine and pulmonary diseases, and had served as a specialist in pulmonary disease at the Trover Clinic since August of 1973. *Dx.* 24 at 4. He was a consultant for the United Mine Workers' of America, Welfare and Retirement Fund from 1973 to 1977. *Dx.* 24 at 4. He also served as a participant at a symposium on "Cardiorespiratory Diseases of Coal Workers" in 1976. *Dx.* 24 at 4.

Dr. Gallo testified that he examined and tested Mr. W, and prepared a report dated October 15, 1981. *Dx.* 24 at 5. He found that the x-ray study conducted in conjunction with the examination yielded negative findings for coal workers' pneumoconiosis. *Dx.* 24 at 9. Moreover, based on his x-ray, Dr. Gallo concluded that there "would be no contra-indication to (the miner) working." *Dx.* 24 at 9. He stated that the pulmonary function studies from Dr. Anderson yielded normal values, and would not indicate the presence of a pulmonary dysfunction or disability. *Dx.* 24 at 12. Dr. Gallo confirmed that the resting blood gas study revealed hypoxemia, but he stated that he would not automatically find Mr. W. disabled based on this study, because "This may be produced at any one particular time of the day by the position of the patient or by the depth of his ventilation on that, at that particular time." *Dx.* 24 at 14.

When asked what would be the underlying cause of Mr. W.'s hypoxemia, Dr. Gallo reported, "Any number of lung conditions, and also heart conditions can also produce hypoxemia of that sort." *Dx.* 24 at 15. Dr. Gallo stated that, by history, he was unable to diagnose chronic bronchitis because Mr. W.'s cough was non-productive. *Dx.* 24 at 16. Dr. Gallo confirmed that he had only examined Mr. W. one time. *Dx.* 24 at 16. He stated:

> It's normally non-productive. Which indicates to me that predominantly it is non-productive. And the definition, the minimum definition of bronchitis is cough and sputum production three months out of the year for at least two consecutive years. That's the minimum definition, by history, to make a diagnosis of bronchitis.

Dx. 24 at 17.

Dr. Gallo concluded that the chest x-ray did not show the presence of pneumoconiosis, and that Mr. W.'s pulmonary function and blood gas studies did not yield evidence of a pulmonary disability. *Dx.* 24 at 20. He attributed Mr. W.'s disability to heart disease.[2]

Dr. William G. West

In a report dated June 29, 1981, Dr. West referred to his findings during an April 20, 1981 examination of Mr. W., where he noted 27 years of coal mine employment, but no history of smoking cigarettes. *Dx.* 11. Examination of the lungs revealed an increased AP diameter as well as "increased resonance to percussion." Cardiac examination produced normal results. A chest x-ray revealed a "generalized increase in interstitial markings and a few scattered nodular densities . . .." Dr. West concluded that "[w]hen coupled with the work history, this x-ray is compatible with a diagnosis of coal workers' pneumoconiosis." Dr. West concluded that Mr. W. was disabled, and stated:

> I believe that this disability is because of shortness of breath and that the shortness of breath, in turn, results primarily from coal workers' pneumoconiosis. The above history and examination strongly suggests to me that (the miner) suffers from coal workers' pneumoconiosis and I believe this pneumoconiosis has been contracted through inhaling coal dust during the entire period that he was employed as a coal miner.

Dx. 11.

Dr. West testified by deposition on December 2, 1981. *Dx.* 23. He stated that he was a general practitioner with a practice in Newburgh and Evansville, Indiana. *Dx.* 23 at 3. He graduated from the Vanderbilt School of Medicine in 1957, and was licensed to practice medicine in Indiana, Kentucky, and Mississippi. *Dx.* 23 at 3-4. In his practice, he treated patients with black lung disease: "Hopkins County is in the Western Kentucky coal field, and I have treated coal miners in large numbers for the past eighteen years, and many of these patients have what we diagnose as black lung." *Dx.* 23 at 4.

Dr. West examined and tested Mr. W., as reflected in his report dated April 20, 1981. *Dx.* 23 at 5. On examination of Mr. W., Dr. West noted:

> Inspection of the chest revealed retraction of the supraclavicular tissues and increase in the AP diameter of the chest. There was increased resonance to percussion. The heart examination was normal. There was clubbing of the fingertips.

Dx. 23 at 6. Dr. West concluded that "all of the positive findings that (he) mentioned were related to, and compatible with, and strongly suggestive of chronic, rather far-advanced lung disease." *Dx.* 23 at 6-7. Dr. West felt that clubbing of Mr. W.'s fingertips was "thought to be

[2] The Board has held that, because Dr. Gallo attributed the miner's disability to heart disease in addition to finding that he suffered from no pulmonary impairment, his opinion *may* be sufficient to demonstrate subsection (b)(3) rebuttal.

due to proliferation of capillaries in the most extreme parts of the body, as far as distance from the heart" and is "thought to be due to a chronic deficit of oxygen in these distant tissues." *Dx.* 23 at 7. Dr. West diagnosed the presence of coal workers' pneumoconiosis based on Mr. W.'s positive x-ray findings and occupational history. *Dx.* 23 at 8-9.

According to Dr. West, Mr. W. "suffers from a breathing disability" that "prevents him from doing any significant manual labor or physical work, because of shortness of breath." *Dx.* 23 at 9. Dr. West noted that Mr. W. would be "totally disabled for doing (coal mining work or manual labor) on a continuous basis." *Dx.* 23 at 9. He concluded that the positive physical findings were indicative of Mr. W.'s disability and stated:

> I don't think we can absolutely say that any one of these is pathognomonic of disability, but all of them taken together make a very strong case for a set of lungs which have become so decompensated that the body's anatomy has had to change in an effort to compensate for these losses of function.

Dx. 23 at 11.

Dr. W.H. Getty

Dr. Getty examined and tested the miner and issued a report on December 27, 1982. *Dx.* 25. He reported 28 years of surface mining where Claimant worked "primarily as an electrical and mechanical repairman." Dr. Getty further noted that the miner "has been a nonsmoker most of his life." He stated:

> In 1976, (the miner) began with dyspnea associated with apparently some sort of heart disease. The physicians in his home felt that he developed some heart difficulties and in 1980 had a three vessel bypass at St. Thomas Hospital in Nashville, Tennessee because of persistent and frequently recurring anterior substernal chest pains brought on by exertion and relieved by rest or Nitroglycerin. This really didn't help his dyspnea, but it did relieve that anginal pain.

Dr. Getty noted that Mr. W. "developed shortness of breath walking one mile very slowly, with which he would have to rest one or two times (on the flat surface)." Further, he stated that "[c]limbing a hill, however, he could not even go more than several blocks." In addition, it was reported that "[t]wo years ago he was able to climb three flights of stairs, but now he can barely make one flight of stairs without stopping." Mr. W. told Dr. Getty that in the past year, "he could not trim his lawn with a pushmower and he has been unable to cut or split wood." He reported some "recurrence of chest pain," and that "[h]e has had a cough for two or three years, occasional dark sputum or mucoid material, no hemoptysis, and he rattles, but doesn't know of any wheeze."

Cardiac examination revealed no murmurs, rubs, or gallop. Examination of the lungs produced no abnormal findings. A chest x-ray revealed "no nodules or infiltrate." Blood gas testing at rest was non-qualifying. Mr. W. exercised on a "variable resistance bicycle

ergometer," but he became "dizzy, faint, weak as if he would fall off the bicycle and the procedure was stopped." Blood gas testing after exercise produced non-qualifying results. Ventilatory testing yielded non-qualifying values pre- and post-bronchodilator.

Dr. Getty concluded that Mr. W. suffered from arteriosclerotic heart disease; he found normal heart size, normal heart rhythm, no murmurs, and "Class III with previous postoperative triple saphenous vein bypass with angina pectoris." Dr. Getty further stated that Mr. W. suffered from chronic bronchitis. However, he concluded that there was no evidence of pneumoconiosis or obstructive pulmonary disease. Dr. Getty stated:

> After reviewing this man's history, physical examination and the pulmonary ventilatory studies, I feel that he does not have coal miner's pneumoconiosis or obstructive pulmonary disease. I feel his cough is based on a chronic bronchitis. This could be most likely caused by coal dust inhalation.
>
> I feel his primary complaint of dyspnea is more related to his coronary artery disease and if his performance on the bicycle ergometer is correct, I suspect that he has very little physical endurance and also has some suggestion of hyperventilation.
>
> I do not feel this man has any significant pulmonary impairment and that his incapacity to work is based on his arteriosclerotic heart disease.

Dr. Getty was associated with the Department of Internal Medicine at the Welborn Clinic in Evansville, Indiana, and specialized in pulmonary diseases.

Dr. William H. Anderson

Dr. Anderson reviewed pulmonary function studies dated June 10, 1986 and issued a report on August 15, 1986, finding the studies to be invalid. He noted that the values between trials varied "considerably more than the allowable 5%." Indeed, Dr. Anderson concluded that "there is no aspect of this study that meets the present standards within the medical community for acceptable pulmonary function studies." However, Dr. Anderson stated that "an FEV1 of 2.4 liters or 73% does indicate a level of ventilatory function that would allow an individual to meet the work demands of a coal miner or do a similar level of work outside of mining."

Dr. Anderson was a Professor of Medicine and Chief of Division of Respiratory and Environmental Medicine at the University of Louisville Department of Medicine.

Dr. Anderson testified by deposition on January 4, 1982. *Dx.* 24. He stated that he was licensed to practice medicine in the State of Kentucky, and was board-certified in internal medicine and pulmonary diseases. *Dx.* 24 at 3. He graduated from the University of Chicago School of Medicine in 1949. *Dx.* 24 at 4. Dr. Anderson recalled that, in 1955 and 1956, he served as an internist and consultant in respiratory and cardiac medicine with a medical group in Cumberland and Lynch, Kentucky where "[t]he majority of the patients were coal miners." *Dx.* 24 at 6. Subsequently, from 1956 to 1963, Dr. Anderson worked as an internist and consultant in

respiratory and cardiac medicine at the Miners Memorial Hospital Association in Harlan, Kentucky, where a majority of patients were miners. *Dx.* 24 at 6. He recalled that '[m]iners with respiratory problems were flown to the Harlan Hospital from most of the coal producing states and from as far away as Alaska for the diagnosis and treatment under my direction." *Dx.* 24 at 6.

Since 1963, Dr. Anderson had been a faculty member at the University of Louisville School of Medicine, where he served as the chief of the Section of Respiratory and Environmental Medicine. *Dx.* 24 at 6. His teaching responsibilities included the "diagnosis and medical treatment of lung disease . . .." *Dx.* 24 at 7. Dr. Anderson stated that, during his ten years at the University of Louisville, he continued to examine coal miners for attorneys, plaintiffs, coal companies, and the "Special Fund." *Dx.* 24 at 8-9. Dr. Anderson has published work regarding research of pulmonary disease in coal miners, including pneumoconiosis. *Dx.* 24 at 9. He served "on the ad hoc advisory committee on occupational pulmonary disease to the National Institute of Occupational Safety and Health." *Dx.* 24 at 11. Dr. Anderson was also "currently serving as a member of the American College of Chest Physicians, Committee to write a handbook for physicians taking care of miners with Black Lung and other respiratory illnesses," which was being written on "contract from the Federal Department of Labor." *Dx*. 24 at 12.

Dr. Anderson testified that he examined and tested Mr. W. on behalf of the Department of Labor, and issued a report on September 29, 1981, finding no pneumoconiosis present, and that Mr. W. suffered from a "respiratory class I impairment, which is a 0% impairment." *Dx*. 24 at 12. Dr. Anderson noted in the report that, under the same guides for heart disease, Mr. W. suffered a class 2 impairment, "which is 20-45% impairment." *Dx*. 24 at 14-15.

Dr. Anderson testified that his pulmonary function testing of Mr. W. revealed values within normal limits. *Dx.* 24 at 16. Mr. W. reported that he quit coal mine work when he experienced "heart trouble." *Dx.* 24 at 16. Dr. Anderson testified that Mr. W. would be unable to perform his usual coal mining work because of his "heart disease." *Dx.* 24 at 17.

On cross-examination, Dr. Anderson testified that he ruled out the presence of pneumoconiosis based on the negative x-ray study and history provided by Mr. W. *Dx.* 24 at 20. He noted that Mr. W. complained of shortness of breath, and he agreed that the symptoms were consistent with the presence of coal workers' pneumoconiosis in "that they do not rule out the presence" of the disease. *Dx.* 24 at 22.

Dr. W. Barton Campbell

By letter dated December 3, 1999, Dr. W. Barton Campbell responded to the issue of whether Mr. W.'s shortness of breath was related to his heart or to lung disease. *ALJx.* 2. In response, Dr. Campbell stated:

> Although you certainly have coronary artery disease we find your heart ejection fraction (the amount of blood ejected from the pumping chamber) to be normal at the time of your last isotope study on 8/16/99. You did have grafts placed to your heart arteries in 1980. I found from the August 1998 catheterization that all of

> these grafts carried good blood flow to your heart. I . . . don't have further data, such as lung function studies, which might be helpful in further evaluating this question. I would suggest that the best test would be a pulmonary function test, which could be carried out either here or in Greenville.

Dr. Campbell further noted that, "[a]s you point out x-rays (which I have not recently seen) have suggested in the past that your lung disease was significant."

Dr. Campbell worked for the Page-Campbell Cardiology Group, which specialized in consultative, diagnostic, and interventional cardiology, as well as cardiac electrophysiology and pacing nuclear cardiology. They were diplomats of the American Board of Internal Medicine and the Subspecialty Board of Cardiovascular Disease.

Dr. William M. O'Bryan

Dr. O'Bryan examined and tested Mr. W., and issued a report on February 8, 2000. *ALJx.* 3. He reported that Mr. W. had 30 years of coal mine employment, with one year of such employment underground, and the remaining 29 years above ground; Mr. W. last engaged in coal mining work on February 28, 1980 as an electrician. Dr. O'Bryan also noted that Mr. W. never smoked. Mr. W. complained of dizziness when he walked, as well as wheezing, dyspnea, coughing (rare), chest pain (using nitroglycerin three times per week), and ankle edema. Mr. W. reported that he could walk to and from his house (200 feet) on flat ground without stopping.

Examination of the lungs revealed "faint early bibasilar early and mid rales" on auscultation. Cardiac examination yielded findings of a "slow pulse" with faint gallop and murmur. A chest x-ray produced findings of Category 0/1 pneumoconiosis. Ventilatory testing produced abnormal results "suggesting mild to moderate restrictive ventilatory impairment" with post-bronchodilator improvement noted. Dr. O'Bryan stated that he suspected "better effort versus a mild obstructive component" on post-bronchodilator testing. Blood gas testing produced non-qualifying values before and after exercise.

Dr. O'Bryan diagnosed a Category 0 chest x-ray, and stated there was no evidence of pneumoconiosis. He felt that Mr. W. suffered from a mild to moderate restrictive ventilatory impairment which was "probably on the basis of previous heart surgery."[3] Mr. W. also suffered from "organic heart disease" and "dyspnea related to age, mild restrictive impairment, and known heart disease." Dr. O'Bryan reiterated that Mr. W. did not have pneumoconiosis. He concluded, however, that Mr. W.'s "dyspnea and ventilatory impairment plus his heart disease would preclude him from performing his last coal mine job of one year's duration." Dr. O'Bryan "suspected" that Mr. W. suffered from "subtle pulmonary fibrosis of aging" and dyslipidemia. In a separate cover letter, Dr. O'Bryan concluded:

> In summary, I do not feel this gentleman suffers from pneumoconiosis.

[3] Dr. O'Bryan conducted a review of certain medical records in conjunction with this report, including numerous x-ray interpretations, depositions of Drs. Marshall and Calhoun, and Dr. Simpao's medical evaluation. He did not, however, have the benefit of reviewing Dr. Campbell's recent December 1999 report regarding Mr. W.'s cardiac status.

> His dyspnea is multifactorial and primarily due to:
> A) A mild restrictive ventilatory impairment from his previous CABG.
> B) Aging lung with subtle pulmonary fibrosis.
>
> His prognosis is as good as anyone seventy-six years old. I don't think any of the above diagnoses can be traced to his underground/aboveground coal mining employment. He did not give me a history consistent with chronic bronchitis.

ALJx 3.

> In an undated letter, Dr. O'Bryan stated the following with regard to Mr. W.'s condition:
>
> Within a reasonable degree of medical certainty, and as a board-certified pulmonary specialist, I can say that in my opinion Mr. Whitman has not contracted an occupationally-related lung disease. I say this without taking into account the results of the chest x-ray which I took during my thorough exam of Mr. [W.].

There were no further findings in this undated letter, and no additional medical data attached to the letter.

Dr. O'Bryan was affiliated with Pulmonary Associates of Owensboro, P.S.C. He was board-certified in internal medicine, pulmonary diseases, and critical care medicine. He graduated with his medical degree from the University of Kentucky in 1976. His private practice was started in July of 1981 and was limited "to pulmonary medicine, critical care medicine, and sleep medicine." He served as the Medical Director of Respiratory Therapy since 1981 at the Owensboro-Daviess County Hospital, and as the Chief of the Department of Medicine of the Hospital from 1994 to 1995. Dr. O'Bryan also served as the Medical Director for Respiratory Therapy at Mercy Hospital since 1986, and was the Medical Director for the Center of Sleep Disordered Breathing since 1994. Dr. O'Bryan was a certified NIOSH B-reader from 1994 to 1998, and he completed a written piece, "Review of Sleep Medicine and Technology" in 1994.

Dr. Mark D. Glazer

Dr. Glazer examined Mr. W. on a follow-up visit for his coronary artery disease, and prepared a report dated February 11, 2002. *ALJx.* 6. Dr. Glazer noted that Mr. W. was "doing well from a cardiac standpoint." His chest was noted as "clear," and the cardiac examination was "normal." Dr. Glazer stated:

> He does get angina with fast walking or exposure to cold weather. As long as he paces himself, however, he does well. He is not having any angina at rest. He had a TIA before his September coronary arteriogram. This was characterized by temporary loss of memory. In fact, he was driving while it happened and he drove past his home.

> When he got home he was unable to work the TV controls. It resolved quickly and aspirin was added to his medical regimen. He had avoided aspirin for many years after his bypass surgery because of easy brusibility. Unfortunately, back on the aspirin he began to bruise again. He was tried temporarily on Plavix and the same problems occurred. He has finally stopped taking the aspirin and wanted to know our opinion.

Dr. Glazer concluded that, in light of Mr. W.'s coronary disease and "relatively recent history of what might have been a TIA, I do think that some form of anti-platelet therapy is indicated." Dr. Glazer reported that Mr. W. had the following "problem list" of concerns: ischemic heart disease; hypertension; history for gastrointestinal bleeding due to gastritis; coal miner's pneumoconiosis; hyperlipidemia; and status post appendectomy.

Dr. Glazer worked for Page-Campbell Cardiology, which specialized in consultative, diagnostic, and interventional cardiology as well as cardiac electrophysiology and pacing nuclear cardiology. They were diplomats of the American Board of Internal Medicine and the Subspecialty Board of Cardiovascular Disease.

Dr. Robert Powell

Dr. Powell examined and tested Mr. W., and prepared a report on October 2, 2002. *ALJx.* 7. He reported 35 years of coal mine employment, with ten years spent working underground and at the tipple and 25 years working at a strip mine. Mr. W. worked as an electrician in the mines until his retirement in 1980. Dr. Powell noted that Mr. W. "retired because of coronary artery disease and having to have a coronary artery bypass grafting procedure." He further noted that Mr. W. "had not been missing work because of his health prior to retirement." Dr. Powell also stated that Mr. W. never smoked.

Mr. W. complained of shortness of breath for the preceding three to four years, and that he "has to stop because of shortness of breath after walking approximately 200 feet on level ground or up one flight of stairs." Mr. W. did not report orthopnea or paroxysmal nocturnal dyspnea. He coughed "some at night and some during the day but it is not productive." Dr. Powell further reported that "[f]or a good while (Mr. W.) has had brief substernal nonradiating aching and discomfort brought on by exertion and relieved by rest."

Examination of the lungs revealed normal breath sounds. Cardiac examination yielded "[n]ormal tones though they are somewhat distant, no murmurs." An EKG demonstrated "left ventricular hypertrophy." A chest x-ray produced the following findings:

> The hilar structures are normal. The diaphragms are normal. There is minimal bilateral pleural thickening. The lungs are well-expanded. The pulmonary vasculature is normal. The nodularity consistent with coal workers' pneumoconiosis is not present. When compared with the standard radiographs, this subject's film is in Category 0/0.

Blood gas testing yielded non-qualifying values; ventilatory testing produced qualifying FEV1 values. The MVV maneuvers were not performed. Dr. Powell noted that the FVC values did not reveal disability. He concluded that Mr. W. did not suffer from coal workers' pneumoconiosis or any significant respiratory impairment. He noted "[m]inimal pleural thickening bilaterally of uncertain etiology," and that Mr. W. was "[s]tatus post CABG for coronary artery disease."

Dr. Powell was affiliated with Kentuckiana Pulmonary Associates, PLLC, and was board-certified in internal and pulmonary medicine. He graduated with his doctorate of medicine in 1966 from the University of Louisville School of Medicine. At the time, Dr. Powell served as a Consultant in Pulmonary Medicine at the Norton Hospital. He was the author of publications on the effects of smoking as well as an article on "Arterial Blood Gases" published in the Journal of Kentucky Medical Association in 1974. Dr. Powell also made numerous presentations in the area of pulmonary medicine.

Dr. Gregory J. Fino

Dr. Fino reviewed certain medical records, and prepared a report dated November 10, 2002. *ALJx.* 8. By letter dated December 11, 2002, Employer clarified that Dr. Fino only reviewed the August 30, 2002 pulmonary function study for purposes of determining whether it was valid.

Dr. Fino reported 35 years of coal mine employment, with ten years spent working underground; Mr. W. stopped working in the mines in 1980 due to coronary artery disease; he never smoked.

Dr. Fino invalidated ventilatory testing dated August 30, 2002 "because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings." He concluded that the study represented, at the least, Mr. W.'s minimal lung function.

Dr. Fino was board-certified in internal medicine and pulmonary diseases, and a NIOSH-certified B-reader. He graduated with his doctorate of medicine from the University of Pittsburgh School of Medicine in 1976. He was the author of publications pertaining to sclerosis and pulmonary function testing.

III
Discussion and Conclusions

Under 20 C.F.R. § 727.203(a)(2), Mr. W. is entitled to a rebuttable presumption of total disability due to pneumoconiosis. As a result, the burden shifts to Employer to demonstrate by a preponderance of the evidence that either: (1) the miner's total disability did not arise in whole or in part from his coal dust exposure (§ 727.203(b)(3)); or (2) the miner does not suffer from pneumoconiosis (§ 727.203(b)(4)). *Gibas v. Saginaw Mining Co.*, 748 F.2d 1112, 1120 (6th Cir. 1984), *cert. denied,* 471 U.S. 1116 (1985); *Burt v. Director, OWCP*, 7 B.L.R. 1-197 (1984).

The Board has appropriately noted that, in determining whether rebuttal is accomplished in this claim, I should focus on evidence that post-dates the February 2000 ventilatory study, which was used to invoke the interim presumption.[4] I also note the considerable span of time between the medical evidence generated from 1978 through 1982, and the evidence generated from 1986 through 2002. The recent medical evidence of record, if it is sufficiently documented and reasoned, will be more probative of Mr. W.'s current physical condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (a report based on a more recent examination of the miner may be accorded greater weight as providing a more accurate evaluation of the miner's current condition). Accordingly, I will weigh all of the reports of record to determine whether Employer has sustained its burden in demonstrating subsection (b)(3) or (b)(4) rebuttal, being mindful that reports pre-dating the February 2000 pulmonary function study may not reflect Mr. W.'s current physical condition as accurately as reports that are contemporaneous with the study.[5]

Rebuttal under § 727.203(b)(3)

Employer maintains that, under subsection (b)(3), rebuttal of the interim presumption is accomplished if "the evidence attributes the total disability to some condition or source other than coal mine employment." (Employer's Brief at p. 10). Thus, Employer argues that

> This is a case in which the evidence overwhelmingly demonstrates (Mr. W.'s) inability to work results from coronary artery disease – the very condition that led to (Mr. W.'s) retirement in 1980 – and advanced age. Neither heart disease nor old age is, however, compensable even under the more liberal eligibility criteria at Part 727.

(Employer's Brief at p. 10). Employer cites to *Youghiogheny & Ohio Coal Co. v. Webb*, 49 F.3d 244, 250 (6th Cir. 1995), stating that "if pneumoconiosis is at least a contributing cause to a miner's disability . . . is he conclusively entitled to benefits." (Employer's Brief at p. 10).

The Sixth Circuit provided further clarification on the weighing of evidence on rebuttal under this subsection, in *Warman v. Pittsburgh & Midway Coal Mining Co.*, 839 F.2d 257 (6th Cir. 1988), in which it reiterated that:

> [S]ection 727.203(b)(3) rebuttal has nothing to do with the degree of a miner's disability. On the contrary, it concerns the burden placed upon an employer in order to rebut the interim presumption of section 727.203(a). Specifically, section 727.203(b)(3) provides an employer the opportunity to rebut the presumption that a miner is 'totally disabled' by 'establish[ing] that the *total disability* did not arise in whole or in part out of coal mine employment.'

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[4] In its March 5, 1998 *Decision and Order*, the Board cited to *Copley v. Island Creek Coal Co.*, 845 F.2d 622 (6th Cir. 1988), holding that the interim presumption would be of little value if it can be rebutted by medical opinions derived from examinations conducted at a time before Claimant established the conditions required to invoke the presumption, *i.e.* before the qualifying and valid February 8, 2000 ventilatory study in this case.

[5] Dr. Fino's report was limited to determining the validity of the August 2002 pulmonary function study. As such, his report is not probative of rebuttal under either subsection (b)(3) or (b)(4).

Thus, the issue presented is whether the medical opinions of record are sufficient to sustain Employer's burden of demonstrating that Mr. W.'s total disability did not arise in whole or in part out of coal dust exposure. I conclude that they are not.

In his 1978 report, Dr. Simpao noted that Mr. W.'s "pulmonary disability appears to be total" and that his pulmonary condition "could be" caused by his work as a coal miner. Because it is Employer's burden to demonstrate that pneumoconiosis did not contribute to Mr. W.'s total disability, Dr. Simpao's finding of an apparently disabling pulmonary disability that could be due to Mr. W.'s coal mine work does not assist the Employer under subsection (b)(3).

Dr. Calhoun, in his 1981 report, concluded that Mr. W. was totally disabled due to coal workers' pneumoconiosis and coal dust induced chronic obstructive pulmonary disease. As a result, his report does not support Employer's burden under subsection (b)(3).

Dr. Gallo, in his 1981 report and deposition, attributed Mr. W.'s disability to cardiac disease, and concluded that he did not suffer from a "pulmonary dysfunction or disability." However, Dr. Gallo's report loses probative force, because it is based on non-qualifying ventilatory study data obtained in 1981, which pre-dates by 19 years the February 8, 2000 study conducted by Dr. O'Bryan that was used to invoke the presumption in this case.[6]

Moreover, Dr. Gallo's conclusion that Mr. W. is disabled by his pre-existing cardiac condition does not, standing alone, satisfy Employer's burden under subsection (b)(3). *See McAngues, supra* ("[a]n employer cannot rebut the presumption (under § 727.203(b)(3)) by showing a second (pre-existing) disability that is entirely independent of Claimant's disabling pneumoconiosis"). In rendering this causation opinion, Dr. Gallo relied heavily on Mr. W.'s reported history:

> [Mr. W.] stopped work in February of 1980 because he had noticed increasing dyspnea such as walking up about 20 steps accompanied by anterior chest discomfort. He later found it was due to coronary artery disease and underwent coronary by-pass surgery March 19, 1980.

An EKG conducted by Dr. Gallo revealed a "small Q in lead II, deep Q in lead III, and minimal Q in AVF." He also noted "some nonspecific T-wave changes, otherwise no diagnostic changes." On the other hand, more recent evidence in the form of Dr. Campbell's December 1999 report demonstrates that Mr. W. had good blood flow to and from his heart, such that Dr. Campbell felt that his shortness of breath could not be explained by his heart surgery or coronary artery disease. Dr. Campbell's report was based on specific cardiac testing, *i.e.* a 1998 catheterization and 1999 isotope study. I note that Dr. Campbell worked with the Page-Campbell Cardiology Group, which specializes in consultative, diagnostic, and interventional cardiology, as well as cardiac electrophysiology and pacing nuclear cardiology. Dr. Gallo's causation opinion loses probative force in light of Dr. Campbell's more recent testing and report, as compared to Dr. Gallo's reliance on Mr. W.'s history and symptoms in 1981, coupled with his

[6] *See* footnote 3.

failure to explain how, if at all, the EKG results underlying his report supported his opinion. Thus, Dr. Gallo's report is not sufficient to sustain Employer's burden under subsection (b)(3).

Dr. West, in his 1981 report and deposition, concluded that Mr. W. was disabled because of his shortness of breath which, in turn, stemmed "primarily from coal workers' pneumoconiosis." Because Employer's burden is to present evidence that pneumoconiosis did not contribute to Mr. W.'s disability, Dr. West's opinion does not aid Employer under subsection (b)(3).

Dr. Getty, in his 1982 report, concluded that Mr. W. was disabled based on his arteriosclerotic heart disease. He found that Mr. W.'s chronic bronchitis "could be most likely caused by coal dust inhalation," but it was not disabling. He did not find that Mr. W. had "any significant pulmonary impairment" such that his "incapacity to work is based on his arteriosclerotic heart disease." Dr. Getty's report does not aid Employer in demonstrating subsection (b)(3) rebuttal because it is based on medical data obtained 18 years before the qualifying February 2000 pulmonary function study conducted in this case. [7]

He also opined that Mr. W.'s complaint of dyspnea "is more related to his coronary artery disease . . .." As did Dr. Gallo, Dr. Getty relied heavily on Mr. W.'s reported history in 1982, and he stated:

> In 1976, (Mr. W.) began with dyspnea associated with apparently some sort of heart disease. The physicians in his home staff felt that he developed some heart difficulties and in 1980 (he) had a three vessel bypass at St. Thomas Hospital . . . because of persistent and frequently recurring anterior substernal chest pains brought on by exertion and relieved by rest and nitroglycerin. This really didn't help his dyspnea, but it did relieve the anginal pain.

After the surgery, on exertion, Mr. W. reported "some recurrence of chest pain." Examination of the heart by Dr. Getty revealed "no murmurs, rubs, or gallop" and a "[n]ormal sinus rhythm." While exercising for blood gas testing, Mr. W. did not report chest pain, but the test had to be stopped because he felt "dizzy, faint, weak as if he would fall off the bicycle . . .." In contrast, Dr. Campbell's December 1999 report, which is based on a 1998 catheterization and 1999 isotope study, revealed that Mr. W.'s coronary artery disease and 1980 cardiac surgery did not account for his shortness of breath. Dr. Campbell's findings are more probative than the findings of Dr. Getty, who based his opinion (that Mr. W.'s dyspnea was related to his cardiac problems) on Mr. W.'s reported history of heart disease in 1982 and the 1980 heart surgery. Dr. Getty did not cite to probative testing that would support his opinion. Indeed, examination of Mr. W.'s heart did not produce any abnormal sounds according to Dr. Getty, and Mr. W. had a "normal sinus rhythm." As a result, Dr. Getty's report is insufficiently documented and reasoned to assist Employer in establishing subsection (b)(3) rebuttal.

Dr. Anderson, in his 1981 examination report, concluded that Mr. W. was totally disabled due to heart disease. He found no respiratory impairment, based on the non-qualifying pulmonary function study values underlying his report. As with the opinions of Drs. Gallo and

[7] *See* footnote 3.

Getty, Dr. Anderson's opinion does not sustain Employer's burden under subsection (b)(3), because it is based on pulmonary function data gathered in 1981, which pre-dates the February 2000 qualifying pulmonary function study used to invoke the interim presumption.[8]

With regard to his conclusion that Mr. W. is disabled due to heart disease, Dr. Anderson's diagnosis is based on Mr. W.'s history:

> He stopped working 2/28/80 because of heart trouble. He had a heart operation in March, 1980. He was then on sick leave and was retired in February 1981. He has been short of breath since the last three years he worked.
>
> . . .
>
> He does have some chest pain that occurs with exertion . . ..

However, an EKG was "[w]ithin normal limits," and no murmurs were heart on examination of the heart. On the other hand, as previously noted, Dr. Campbell's December 1999 report cites to Mr. W.'s 1998 catheterization and 1999 isotope study as demonstrating good blood flow in and out of the heart, such that Mr. W.'s shortness of breath could not be explained by his coronary artery disease or his previous heart surgery. Dr. Anderson failed to adequately explain how Mr. W.'s heart problems were the cause of his disability, in light of the normal EKG underlying his report. Thus, Dr. Anderson's report is not sufficiently documented or reasoned to sustain Employer's burden under subsection (b)(3).

In his February 2000 report, Dr. O'Bryan concluded that Mr. W.'s dyspnea, ventilatory impairment, and heart disease would preclude him from performing his last coal mining job of one year's duration. This supports a finding that Mr. W. is totally disabled due, in part, to his ventilatory impairment, which is consistent with the qualifying and valid pulmonary function study underlying Dr. O'Bryan's report.

Dr. O'Bryan attributed Mr. W.'s total disability to a combination of heart disease and dyspnea stemming from "[a]ging lung" and heart disease. Mr. W. was 76 years old at the time of Dr. O'Bryan's February 2000 examination and testing, and his history of heart disease is well-documented on this record. In concluding that Mr. W.'s ventilatory impairment and dyspnea stemmed from cardiac disease, Dr. O'Bryan cited to the history provided by Mr. W., *i.e.* that he had coronary artery bypass surgery in 1980, and that he experienced chest pain on exertion. Examination of the chest by Dr. O'Bryan revealed a faint murmur, but no thrills or rub. The rhythm was normal. No EKG testing was conducted. On the other hand, Dr. O'Bryan did not have Dr. Campbell's December 3, 1999 report or testing to review and consider. In his December 3, 1999 report, Dr. Campbell stated:

> Although you certainly have coronary artery disease we find your heart ejection fraction (the amount of blood ejected from the pumping chamber) to be normal at the time of your last isotope study on 8/16/99. You did have grafts placed to your

[8] *See* footnote 3.

> heart arteries in 1980. I found from the August 1998 catheterization that all of these grafts carried good blood flow to your heart.

Thus, citing to specific cardiac testing, *i.e.,* an isotope study dated August 16, 1999 and a catheterization dated August of 1998, Dr. Campbell opined that Mr. W. had "good blood flow" to his heart and a normal heart ejection fraction. Dr. Campbell acknowledged Mr. W.'s history of coronary artery disease, but he could not explain Mr. W.'s shortness of breath based on his cardiac disease or his 1980 cardiac surgery, and he suggested that Mr. W. undergo a pulmonary function study. Dr. Campbell's contemporaneous findings, based on specific cardiac testing, diminish the reliability of Dr. O'Bryan's opinion that cardiac disease caused, in part, Mr. W.'s disabling ventilatory impairment. Thus, Dr. O'Bryan's opinion is not sufficiently probative to sustain Employer's burden under subsection (b)(3).

In his 2002 report, Dr. Powell concluded that Mr. W. suffered from "post CABG for coronary artery disease" and "minimal pleural thickening bilaterally of uncertain etiology", but that he did not suffer from "any significant respiratory impairment."[9] The Sixth Circuit has emphasized that rebuttal under subsection (b)(3) is not focused upon the extent of a miner's disability; rather, it addresses the cause of his disability. *See Gibas, supra*.

Here, Dr. Powell attributed Mr. W.'s disability to coronary artery disease. The only information Dr. Powell cited in support of his opinion was from the history provided by Mr. W., as follows:

> [Mr. W.] worked until he retired in 1980. He retired because of coronary artery disease and having to have a coronary artery bypass grafting procedure.

ALJx. 7. Mr. W. complained of "brief substernal nonradiating aching and discomfort brought on by exertion and relieved by rest." Dr. Powell noted that Mr. W.'s "past history is positive for hypertension and heart trouble for which he takes medication." Examination of the heart revealed "[n]ormal tones" and "no murmurs." An EKG yielded findings "consistent with the previous anteroseptal myocardial infarction and shows a sinus bradycardia and meets the electrical criteria for left ventricular hypertrophy." Dr. Powell did not explain how, if at all, the EKG finding supported his opinion that Mr. W.'s disability was due to coronary artery disease. As with Dr. O'Bryan, Dr. Powell did not have the benefit of reviewing Dr. Campbell's December 3, 1999 report. The fact that Dr. Campbell found that Mr. W. had good blood flow to his heart and a normal ejection fraction, based on a 1999 isotope study and 1998 catheterization, compromises Dr. Powell's conclusion that Mr. W.'s disability was attributable to his heart disease. Dr. Campbell concluded, based on specific cardiac testing, that Mr. W.'s shortness of

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[9] Dr. Powell's October 2, 2002 study produced qualifying FEV1 values. Although this study was found to be valid, there were no MVV maneuvers, and thus it could not be determined from the tables at Part 727 whether the overall test was qualifying. Dr. Powell opined that Mr. W.'s FVC demonstrated that his total lung capacity was normal. However, the FVC value obtained by Dr. Powell was similar to that obtained in testing conducted by other physicians of record starting in 1986. These same tests, however, also yielded qualifying MVV values, including Dr. O'Bryan's valid and qualifying February 2000 testing. Thus, Dr. Powell's qualifying FEV1 values lend support to Dr. O'Bryan's recent qualifying test of record, and the fact that Mr. W.'s FVC value was not qualifying during Dr. Powell's testing does not also compel a finding that the MVV, if conducted, would have been non-qualifying.

breath could not be explained by his long-term cardiac disease or his 1980 heart surgery. In sum, I do not find Dr. Powell's opinion to be sufficient to sustain Employer's burden of establishing rebuttal under subsection (b)(3).

Upon review of all of the medical opinions of record, I find that the Employer has not presented sufficiently reasoned and documented opinions to establish rebuttal under § 727.203(b)(3).

Rebuttal Under § 727.203(b)(4)

It is well-settled at this juncture that Employer has rebutted the interim presumption that Mr. W. suffers from clinical pneumoconiosis, based on the preponderantly negative x-ray evidence of record. However, in *Youghiogheny & Ohio Coal Co. v. Webb*, 49 F.3d 244 (6th Cir. 1995), the Sixth Circuit held that, standing alone, "[n]egative x-rays are not sufficient to rebut the interim presumption." Rather, in *Campbell v. Consolidation Coal Co.*, 811 F.2d 302 (6th Cir. 1987), the Court clarified that, to establish subsection (b)(4) rebuttal, the party opposing entitlement must also present evidence sufficient to rebut the presumption that the miner suffers from *legal* pneumoconiosis. The burdens of *production and persuasion* shift to the Employer on rebuttal. *Youghiogheny & Ohio Coal Co. v. McAngues*, 996 F.2d 130, 133 (6th Cir. 1993), *cert. denied,* 510 U.S. 1040 (1994). Here, as previously discussed, ventilatory testing over time demonstrates that Mr. W.'s respiratory condition has worsened. I note that this is consistent with an irreversible and progressive disease process such as pneumoconiosis. *Peabody Coal Co. v. Odom*, 342 F.3d 486 (6th Cir. 2003) (pneumoconiosis is a progressive and latent disease that "can arise and progress even in the absence of continued exposure to coal dust"). However, I am also mindful that pulmonary function testing, standing alone, is not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In this case, Employer must present evidence sufficient to demonstrate that Mr. W. does not suffer from a chronic pulmonary disease significantly related to, or aggravated by, dust exposure in coal mine employment. *See* 20 C.F.R. § 727.202 ("pneumoconiosis" defined). Thus, the issue is whether the medical opinions of record are sufficient to sustain Employer's burden of demonstrating that Mr. W. does not suffer from pneumoconiosis. I conclude that they are not.

While Mr. W. was working in the mines in 1978, Dr. Simpao noted that he suffered from progressively worsening shortness of breath. Based on Mr. W.'s history and examination, Dr. Simpao diagnosed the presence of chronic bronchitis and chronic pulmonary fibrosis. With regard to the cause of the chronic bronchitis, Dr. Simpao stated that "some inhalation of dust might cause this kind of irritation in the bronchial tree." While Dr. Simpao's opinion is equivocal in attributing Mr. W.'s respiratory ailment to his coal dust exposure, it is insufficient to demonstrate subsection (b)(4) rebuttal, as the expert must unequivocally conclude that the miner does not suffer from a coal dust induced disease. *Heavilin v. Consolidation Coal Co.*, 6 B.L.R. 1-1209 (1984). [10]

[10] In *Youghiogheny and Ohio Coal Co. v. Selak*, 65 F.3d 169 (6th Cir. 1995)(unpub.), the Court noted that, when an employer demonstrates that the miner does not suffer from clinical pneumoconiosis, the burden does not then shift to the miner to present evidence "supporting a *positive* fact finding by the administrative law judge of legal

Similarly, in 1981, Dr. Calhoun found, after examination and testing, that Mr. W. was a "terrible pulmonary cripple." He diagnosed "a lot of emphysema" and chronic obstructive pulmonary disease related, in part, to Mr. W.'s exposure to coal dust. Because Dr. Calhoun diagnosed the presence of legal pneumoconiosis in his opinion, it does not aid Employer in demonstrating subsection (b)(4) rebuttal.[11]

In 1981, Dr. Gallo noted that Mr. W. could walk one-half mile before noticing dyspnea, and that he suffered from a non-productive cough. At that time, Dr. Gallo found that Mr. W. did not have any pulmonary dysfunction, based on Dr. Anderson's non-qualifying pulmonary function study. He further stated that he could not diagnose chronic bronchitis, because Mr. W.'s cough was non-productive. He noted "dyspnea," but concluded that Mr. W. suffered from "status post-coronary by-pass surgery for coronary artery disease and angina pectoris." Based on a negative x-ray interpretation, Dr. Gallo found no clinical pneumoconiosis, which is consistent with my findings on this record.

Dr. Gallo did not diagnose the presence of legal pneumoconiosis. But I find that his opinion is insufficient to rebut the presumption of legal pneumoconiosis, as it is based on medical data generated in 1981. Because pneumoconiosis is a latent and progressive disease, it is reasonable to accord less weight to an opinion based on medical data pre-dating the February 2000 pulmonary function study.[12] *See Odom, supra.* Dr. Gallo's opinion, that Mr. W. did not suffer from any pulmonary dysfunction, was based on non-qualifying pulmonary function testing generated nearly 19 years before Dr. O'Bryan's qualifying February 2000 study. Consequently, it does not constitute persuasive evidence in support of subsection (b)(4) rebuttal.

Dr. West, in his 1981 report and deposition, concluded that Mr. W. was disabled due to shortness of breath stemming from coal workers' pneumoconiosis. He noted an increased AP diameter in Mr. W.'s chest, and clubbing, compatible with "and strongly suggestive of chronic, rather far-advanced lung disease." Dr. West diagnosed the presence of clinical pneumoconiosis. However, he did not specifically address the presence, or absence, of legal pneumoconiosis. As a result, his opinion does not sustain Employer's burden under subsection (b)(4).[13]

In 1982, Dr. Getty diagnosed the presence of dyspnea "associated with apparently some sort of heart disease." Dr. Getty noted that Mr. W. developed shortness of breath while walking one mile very slowly, and that "he could not even go more than several blocks." Dr. Getty further noted that Mr. W. could not climb one flight of stairs without stopping. He concluded that Mr. W. suffered from chronic bronchitis that "could be most likely caused by coal dust inhalation." He did not find the presence of clinical pneumoconiosis, based on a chest x-ray interpretation. This is consistent with my findings on this record. However, Dr. Getty concluded that Mr. W. did not suffer from obstructive lung disease, based on the non-qualifying blood gas

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pneumoconiosis outweighing the admittedly negative x-ray evidence;" rather, the Court held that the burden remains with the employer to demonstrate that the miner does not suffer from legal pneumoconiosis.

[11] *See* footnote 9.
[12] *See* footnote 3.
[13] *See* footnote 9.

and ventilatory testing underlying his report. The reliability of his finding of no obstructive lung disease is compromised, as it is based on medical data generated in 1982, nearly 18 years before the February 2000 qualifying study used to invoke the interim presumption. I note that Dr. Getty did diagnose the *possible* presence of legal pneumoconiosis, *i.e.* chronic bronchitis that "could be" due to coal dust exposure. Although Dr. Getty's diagnosis of chronic bronchitis is questionable given the variable histories reported in this record, the burden of production and persuasion is on Employer to demonstrate that Mr. W. does not suffer from legal pneumoconiosis under subsection (b)(4). Because Dr. Getty's opinion leaves open the possibility that Mr. W. suffers from a coal dust induced lung disease, and he has not unequivocally concluded that Mr. W. does not suffer from legal pneumoconiosis, his opinion is insufficient to support rebuttal under subsection (b)(4).[14]

Dr. Anderson examined Mr. W. in 1981 and concluded, based on non-qualifying ventilatory testing, that he did not suffer from a respiratory impairment. He further concluded that Mr. W. did not suffer from clinical pneumoconiosis, based on a negative x-ray study and his history. Dr. Anderson's finding of no clinical pneumoconiosis is consistent with my finding on this record. However, Dr. Anderson's conclusion that Mr. W. did not have a respiratory impairment is not probative, as it is based on medical data generated in 1981, 19 years before Dr. O'Bryan's qualifying February 2000 study used to invoke the interim presumption.[15] Again, Employer has the burden of persuasion and production to demonstrate that Mr. W. does not suffer from legal pneumoconiosis; Dr. Anderson's opinion, which is based on medical data generated in 1981, is insufficient to aid Employer in this regard.

Drs. Campbell and Glazer are affiliated with Page-Campbell Cardiology and they issued reports in 1999 and 2002, respectively. Dr. Campbell notes the presence of lung disease of unspecified etiology. Dr. Glazer notes the presence of coal workers' pneumoconiosis as one of several ailments suffered by Claimant. Neither physician concludes that the miner does not suffer from legal pneumoconiosis and, as a result, their reports do not support Employer's burden under subsection (b)(4). *See Heavilin, supra*.[16]

Dr. O'Bryan issued one of the more recent reports, dated February 8, 2000. He concluded that Mr. W. did not suffer from clinical pneumoconiosis, based on the negative chest x-ray interpretation underlying his report; this is consistent with my findings on this record. However, while Dr. O'Bryan concluded that Mr. W. suffered from dyspnea and a ventilatory impairment, he attributed these conditions to "[a]ging lung" and heart disease. Dr. O'Bryan's finding of a ventilatory impairment is probative, as it is supported by his qualifying and valid pulmonary function study, which was used to invoke the presumption in this case.

However, Dr. O'Bryan's conclusion that Mr. W. does not suffer from legal pneumoconiosis, and that his ventilatory impairment stems, in part, from "his previous CABG", *i.e.* previous heart surgery and cardiac disease, is not sufficiently reasoned or documented. Within his report, Dr. O'Bryan cited to the history provided by Mr. W., *i.e.* that he had coronary

[14] *See* footnote 9.

[15] In his 1982 deposition, Dr. Anderson noted that Mr. W. complained of shortness of breath, and agreed that the symptoms "do not rule out the presence" of coal workers' pneumoconiosis. *Dx.* 24 at 22. *See also* footnote 3.

[16] *See* footnote 9.

artery bypass surgery in 1980, and that he experienced chest pain on exertion. Examination of the chest by Dr. O'Bryan revealed a faint murmur, but no thrills or rub. The rhythm was normal. No EKG testing was conducted. As previously noted, Dr. O'Bryan did not have the opportunity to review and consider Dr. Campbell's December 1999 report. In this report, Dr. Campbell cited to the August 1998 catheterization and August 1999 isotope study in stating that Mr. W.'s previous heart surgery and coronary artery disease could not explain his shortness of breath. Indeed, Dr. Campbell stated that Mr. W. had good blood flow to and from the heart. Dr. Campbell's conclusions, in addition to Dr. O'Bryan's failure to adequately explain how his findings on examination supported his opinion, compromise the probative value of Dr. O'Bryan's causation opinion. Consequently, Dr. O'Bryan's report, though it is more recent in this record, is insufficient to sustain Employer's burden in demonstrating subsection (b)(4) rebuttal, *i.e.* that Mr. W. does not suffer from legal pneumoconiosis.

Finally, Dr. Powell's 2002 examination and testing of Mr. W., which resulted in his finding of no clinical pneumoconiosis, based on a negative chest x-ray interpretation, is consistent with my findings on this record. However, Dr. Powell also concluded that Mr. W. did not suffer from any significant respiratory impairment. This is not consistent with my findings on this record. Indeed, I have found that Mr. W. suffers from a chronic, disabling respiratory impairment, based on the qualifying pulmonary function testing of record. In contrast, Dr. Powell opined that Mr. W.'s FVC indicated that his total lung capacity was normal, and therefore, he was not disabled from a respiratory standpoint. However, as previously noted, I have found that Dr. Powell's ventilatory testing yielded unclear results under the regulations at Part 727. Specifically, the FEV1 values were qualifying, but Dr. Powell failed to conduct MVV maneuvers, and thus it could not be determined whether the overall test was qualifying under the Part 727 regulations. On the other hand, Dr. O'Bryan conducted contemporaneous testing on February 8, 2000, which was valid and produced qualifying FEV1 and MVV values under the regulations. Thus, Dr. Powell's opinion that Mr. W. does not suffer from a respiratory impairment is compromised by his reliance on unclear pulmonary function testing, as compared to Dr. O'Bryan's finding of a ventilatory impairment based on his valid and qualifying testing.

Dr. Powell did note, however, that Mr. W. complained of shortness of breath, and that he "has to stop because of shortness of breath after walking approximately 200 feet on level ground or up one flight of stairs." Dr. Powell did not specifically address the cause of Mr. W.'s shortness of breath, but he did state that Mr. W. was "[s]tatus post CABG for coronary artery disease." Again, even if I were to find that Dr. Powell attributed Mr. W.'s respiratory symptoms to his heart disease, I would conclude that his opinion is not probative in light of Dr. Campbell's December 1999 report. Notably, Dr. Campbell concluded that Mr. W.'s shortness of breath, which is a well-documented complaint in the medical opinions in this case, could not be explained by his previous cardiac surgery or coronary artery disease. As previously noted, Dr. Campbell cited to specific testing, *i.e.* the 1998 catheterization and 1999 isotope study, in support of his opinion that Mr. W.'s heart disease and surgery were not the cause of his shortness of breath. Based on the foregoing, I find that Dr. Powell's opinion is insufficient to support Employer's burden under subsection (b)(4).

In sum, certain physicians have concluded that Mr. W. did, or *could possibly*, suffer from some form of legal pneumoconiosis (*i.e.* Drs. Simpao, Calhoun, and Getty) and other physicians

were silent on the issue of whether Mr. W. suffered from legal pneumoconiosis (*i.e.* Drs. West, Campbell, and Glazer). While these opinions may not be sufficiently reasoned or documented to support a "*positive* fact finding" of legal pneumoconiosis, the burden here is not on Mr. W. Rather, Employer bears the burden of production and persuasion, and must present reasoned and documented medical evidence demonstrating that Mr. W. does not suffer from the disease.[17] As a result, these opinions are not sufficient to sustain Employer's burden.

In addition, medical opinions finding no respiratory or pulmonary impairment are not probative of subsection (b)(4) rebuttal, either because they are based on medical data generated many years before Dr. O'Bryan's ventilatory test (*i.e.* Drs. Gallo and Anderson), or they are based on less probative ventilatory testing than that underlying the Part 727 presumption (*i.e.* Dr. Powell).

Finally, in determining whether Employer has sustained its burden under subsection (b)(4), I have found the Sixth Circuit's opinion in *Campbell* to be instructive, *to wit*:

> Both Dr. Anderson and Dr. Orza agreed that Campbell suffered from pulmonary impairment. Campbell's thirty-five years of employment in the coal mines constitute sufficient evidence to indicate that his exposure to coal dust at least aggravated his condition. This, coupled with the most recent ventilatory study invoked the presumption and constituted substantial evidence on which the administrative law judge properly based his initial decision (finding subsection (b)(4) rebuttal not established).

Id. at 304.

In this case, Dr. O'Bryan concluded that Mr. W. suffered from a disabling ventilatory impairment. Mr. W.'s 30 or more years of employment in and around the coal mines is sufficient evidence to indicate that his exposure to coal dust at least aggravated his condition. This, coupled with the February 8, 2000 ventilatory study that is qualifying and conforming, and yielded results established by the tables under Part 727, invoked the presumption, and constitutes substantial evidence of total disability due to pneumoconiosis. Employer has not presented sufficiently reasoned and documented opinions to sustain its burdens of production and persuasion under subsection (b)(4) to rebut this presumption. Thus, Mr. W. is entitled to benefits under the Act.

[17] *See* footnote 9.

IV
Date of Onset

Mr. W. argues that a designation of April 1, 1978 as the onset date is proper *provided* that I "make clear that the Department of Labor is required to suspend benefits during the time Mr. [W.] was still working" pursuant to 20 C.F.R. § 725.504. The Board has held that the date of onset must be reconsidered, because benefits cannot commence as of the date the claim was filed in this matter (April 1, 1978), since Mr. W. did not stop working in the coal mines until February 27, 1981. *Dx.* 4; 20 C.F.R. § 725.503. Moreover, benefits may not be awarded for any time period during which Mr. W. was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). I also note that the date of the first medical evidence of record indicating total disability does not necessarily establish the date of onset; rather, the evidence only indicates that Mr. W. became totally disabled at some point before the medical tests revealed his disability. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1306, 1-1310 (1984).

Initially, I find that the medical opinions are not helpful in determining the date of onset in this case. The only two physicians to conclude that Mr. W. is totally disabled due to pneumoconiosis are Drs. Calhoun and West. However, their reports were generated in 1981, and with the exception of Dr. Calhoun's qualifying April 21, 1981 ventilatory study, the ventilatory studies dated November 1978, September 1981, October 1981, and December 1982 yielded non-qualifying values under the regulations. On balance, I find that Mr. W. has not demonstrated that he suffered from a *chronic* totally disabling respiratory impairment, such as that caused by pneumoconiosis, during this time period. Consequently, the opinions of Drs. Calhoun and West are not sufficiently probative to establish the date of onset.

Moving to the two pulmonary function tests conducted in 1986, I note that both tests yielded qualifying values, but neither test was valid. Medical experts concluded that there was too much variation in the efforts among the trials, such that certain results would not be reproducible. As a result, I do not have sufficiently probative medical data upon which to find Mr. W. totally disabled due to pneumoconiosis during this time period.

However, the February 8, 2000 ventilatory study conducted by Dr. O'Bryan is valid and qualifying, and it has supported invocation of the interim presumption of total disability due to pneumoconiosis in this case. Although it is reasonable to assume that Mr. W. became totally disabled at some point in time before February 8, 2000, but after the December 1982 non-qualifying study of Dr. Getty, the intervening medical evidence is not sufficiently probative of a more precise date on which he became totally disabled due to pneumoconiosis. As a result, I find that the onset date for the payment of benefits is February 1, 2000, the month in which Mr. W. demonstrated that he was totally disabled due to pneumoconiosis under Part 727.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED that the claim of J. W. for benefits under the Act is GRANTED.

IT IS FURTHER ORDERED that the Employer shall pay to J. W. all benefits to which he is entitled under the Act commencing in February 2000.

SO ORDERED.

A

LINDA S. CHAPMAN
Administrative Law Judge

ATTORNEY'S FEES

The award of attorney's fees under the Act is permitted only in the cases in which the claimant is found to be entitled to benefits. Since benefits are awarded in this case, the Claimant's attorney may file a fee petition within 30 days of the date of this order.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is:

Benefits Review Board
U.S. Department of Labor
P.O. Box 37601
Washington, DC 20013-7601

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).